

***United States Court of Appeals
for the Second Circuit***



APPENDIX

77-6006

UNITED STATES COURT OF APPEALS
FOR THE SECOND CIRCUIT

MARY COX, as Administratrix of the
Goods, Chattels and Credits of
Bobby Cox, deceased,

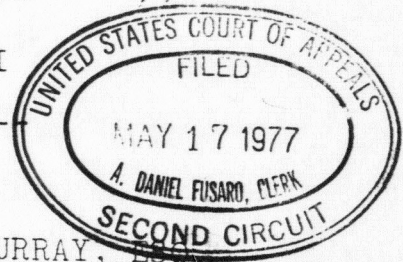
plaintiff-appellant,

- against -

ADMINISTRATOR OF THE VETERANS ADMINI-
STRATION, VETERANS ADMINISTRATION,
UNITED STATES OF AMERICA,

defendants-appellees.

A P P E N D I X VOLUME II



GERALD MURRAY, ESQ.
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McNeil-cross

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1
2 somebody in charge.

3 Q Did you tell them about the 90-day rule over there?

4 A Yes.

5 Q What did they say?

6 A The same answer.

7 Q They didn't understand it?

8 A Right.

9 MR. PARKER: If I could have about two minutes
10 to check over my notes I will finish up.

11 THE COURT: All right.

12 (Pause.)

13 MR. PARKER: I have no further questions. Thank
14 you, Mrs. McNeil.

15 THE COURT: You may step down, Mrs. McNeil.

16 (Witness excused.)

17 THE COURT: Is it correct that except for
18 your expert you rest?

19 MR. MURRAY: Yes.

20 There are certain EBTs I want to introduce.
21 I have taken a number of depositions in this case.

22 THE COURT: How long will you be with your
23 case, do you have any idea? Are you ready to go ahead
24 this afternoon?

25 MR. PARKER: Your Honor, I have one non-expert

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AFTERNOON SESSION2:00 p.m.

THE COURT: Proceed, please.

MR. PARKER: The Government calls Peter A.
Pascarelli as its witness.

P E T E R A. P A S C A R E L L I,

called as a witness by the Government, being first
duly sworn, testified as follows:

DIRECT EXAMINATION

BY MR. PARKER:

Q Mr. Pascarelli, are you employed by the Manhattan
Veterans Administration Hospital?

A Yes.

Q How long have you been employed by that hospital?

A 21 years.

Q What position do you now hold?

A Chief Medical Administration Service.

Q In 1972 what position did you hold?

A I was Assistant Chief, Medical Administration
Service.

Q What did you do as the Assistant Chief of the
Medical Administration Service?

A I was responsible for the admission, processing,
discharges, medical records, release of information

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2 at that hospital.

3 Q Did you supervise any personnel in that capacity?

4 A Yes.

5 Q Did you supervise the admitting staff?

6 A I supervised the admitting staff through my
7 subordinate supervisor.

8 Q Are you familiar with the admissions procedure
9 at the Manhattan VA Hospital as it was in 1972?

10 A Yes, I am.

11 Q Can you please tell us what the procedure for
12 processing an applicant for admission was at that time?

13 A The procedure was that an applicant would come
14 in, go to our reception desk and apply for hospital care.
15 At that time the clerk would take his name, social
16 security number, ask him if he was a veteran, ask him if
17 he was a patient here before and what his complaint was.

18 Q What would happen next?

19 A If he was a patient we would then make out our
20 routing sheet. We would make out a 10M medical certificate.
21 We would request his medical records from the record
22 room. We would then process him through our admitting
23 service, out-patient service, to be seen by a nurse
24 clinician and a physician.

25 Q The patients or the records this is?

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Pascarelli-direct

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1 A The patient. The records would come later.

2 Q While the patient was going on to the next step?

3 A Yes, sir. While he was being processed the
4 records would be secured.
5

6 Q What would happen to the applicant when he saw
7 the medical personnel, the physician and the nurse?

8 A He would be evaluated for his complaints and
9 a medical determination as to hospital care would be
10 made by the examining physician.

11 Q Not by the nurse, but by the doctor?

12 A By the physician.

13 Q Are these procedures any different now than they
14 were in 1972?

15 A No.

16 Q After 4:30 in the afternoon were the procedures
17 any different than before 4:30?

18 A No. The procedures remain the same for 24
19 hours, seven days a week. The staffing would be different.
20 The daytime staff is larger than our staff that we
21 have from 4:00 to 12:00 and 12:00 to 8:00. We have
22 a medical administrative assistant on duty from 4:00
23 to midnight and another one relieves him at midnight
24 to 8:00 with a clerk, when available.

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Q And what about physicians staffing?

A The physician staffing, we have a day staff of approximately six physicians. We have one on from 4:00 to 12:00 and one on from midnight to 8:00. He stays on actually from 4:00 to 8:00 a.m.

Q In 1972 what was the procedure regarding applicants for admission who had earlier received an irregular discharge from the hospital?

A The procedure would be the same as any other applicant who applied.

THE COURT: What is an irregular discharge?

THE WITNESS: Can I answer that?

MR. PARKER: Yes, please do.

THE WITNESS: An irregular discharge is one where a veteran signs himself out, that he doesn't want continued treatment, where he has had an infraction of rules, he refused medication, he refused to comply with the physician's direction and, therefore, signs out against medical advice.

Q Prior to 1972 had there been another rule in effect for patients who had received an irregular discharge prior to applying for admission?

A There was a 90-day exclusion, but the 90-day exclusion only held after a medical determination was made

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2 by the medical staff as to the emergency or the treatment
3 he required. If he required emergency treatment the
4 90-day exclusion rule is waived. The man is admitted
5 and treated. We will give treatment. If it was only
6 treatment, we would render treatment regardless of the
7 90-day exclusion. That only held for readmission.

8 Q But the 90-day rule was not in effect in 1972,
9 is that correct?

10 A No.

11 Q In regard to the 90 day rule who was it that
12 made the determination regarding treatment?

13 A The physician.

14 THE COURT: When did this 90-day rule go into
15 effect?

16 THE WITNESS: The 90-day rule was in effect,
17 I think, until -- I don't know if it was '70 or '71
18 when it was changed and it was done away with where
19 it was -- he was treated like any other veteran, however,
20 he was spoken to as to his previous infractions and that
21 he shouldn't be doing them and he should stay with the
22 treatment because he would be taking up physician time
23 and nursing time and we wouldn't be accomplishing anything
24 for him if he was just going to walk in and out at his
25 own pleasure.

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1 THE COURT: In other words, an irregular patient
2 was still admitted after 1972 at any time that he applied?

3 THE WITNESS: Right. Excuse me, he was also
4 admitted prior to that. When the 90-day exclusion rule
5 was in effect, if an applicant came in and my people
6 would take the application. Now, they would have no
7 knowledge of his type of discharge since we do the
8 application first, have him seen then call for the record.
9 Then the record comes, then we know that he has gone
10 out as an irregular and we give it to the physician.
11

12 Unless he gives this information to the physician.
13 Then the physician makes the determination on the basis
14 of the record, on the basis of what he now needs.

15 If the physician feels that this man should be
16 admitted, he is admitted.

17 THE COURT: That was even under the 90-day exclusion
18 rule?

19 THE WITNESS: Even under the 90-day exclusion
20 rule.

21 THE COURT: But you say in 1972 it was not in
22 effect at all?

23 THE WITNESS: It was not in effect at all.

24 Q In 1972 or at any time for that matter, Mr.
25 Pascarelli, did clerks on the admitting service play any

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2 role in the decision-making process as to admissions?

3 A No.

4 Q As Assistant Chief of Medical Administration,
5 did you instruct the clerical personnel on the
6 admitting service as to their role in the admitting process?7 A We had regular training sessions since our
8 turnover and promotional policies was created. We had
9 regular training programs in processing of applicants.
10 We also had nursing service involved as to our clerks,
11 how to recognize when a man should be seen medically before
12 even an application was taken, by asking what is your
13 problem.14 A good example is if an applicant came in
15 and said, "Gee, I'm having some chest pains and my arm
16 hurts," we wouldn't bother. We would take him into the
17 physician and do the paperwork later. Whether he was a
18 veteran or not, we wouldn't even ask.19 THE COURT: In other words, you are saying that
20 a man who is not entitled to veterans benefits could come
21 in off the street and if there is an indication of a
22 need for immediate treatment, you would do it?23 THE WITNESS: Right. That is humanitarian. We
24 have done it. We would admit him emergency. As soon
25 as the emergency terminates, the family would come in.

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we would tell them that you can move him to a hospital of your choice. We would bill for the service, though. If they have the coverage, they would send it to Blue Cross, Blue Shield or whoever would have it and we would get paid.

Q When a veteran applies for admission what information exactly does your admitting clerk ask for?

A We ask him if he is a veteran. We ask for his name, social security number, if he was a patient here before.

Q If the applicant had been a patient before what does the clerk then do?

A He would take his name, social security number, prepare a routing sheet, 10M, which is the routing slip, a charge slip for the record room to send us the clinical file.

Q And in regard to the patient --

A The patient would be processed. He would go to the nurse for his vital signs, TPRs and then to the physician.

THE COURT: What was that expression?

THE WITNESS: For his temperature, pulse and respiration.

Q Was this before or after the applicant's prior

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2 medical records were delivered to the clerk?

3 A This is done before we get the record.

4 MR. MURRAY: I am going to object to this because
5 we are dealing not with an accident case, we are dealing
6 with a mental case. I think Mr. Parker's questions are
7 dealing with injuries that come in. I think it is a
8 different situation.

9 THE COURT: objection overruled.

10 MR. MURRAY: Thank you, your Honor.

11 Q Mr. Pascarelli, is this the procedure in regard
12 to any applicant at the hospital?

13 A Any applicant.

14 Q Mr. Pascarelli, where are the records of prior
15 hospitalization kept at the hospital?

16 A In the medical record room. In the inactive
17 record room.

18 Q Where is that in relation to the admitting desk
19 of the hospital?

20 A I would say it is maybe 200 feet. Maybe a
21 little better.

22 Q Generally, if you know, in 1972, on the 4:30
23 to 12:00 shift, approximately how long did it take for
24 records to be routed from the record room to the
25 admitting desk?

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2 A Well, the clerk who was on duty would have to
3 go down and get it, since the record room closes at 4:30
4 at that time. We didn't have round-the-clock coverage
5 in the record room, so if he was tied up with an applicant,
6 the come first, the records come second. Since the
7 physician can evaluate the veteran, it doesn't really
8 require the record.

9 Q Can you put an approximate time on that or is
10 it impossible to do?

11 A You can. We usually get it within a half hour.

12 MR. PARKER: I have no further questions, your
13 Honor.

14 CROSS EXAMINATION

15 BY MR. MURRAY:

16 Q Mr. Pascarelli, you spoke about a 90-day rule, is
17 that correct?

18 A Yes.

19 Q Do you have that rule with you here today, sir?

20 MR. PARKER: Mr. Murray, I have got a copy of
it as I sent you a copy of it.

MR. MURRAY: If you could point it out to me I
would appreciate it.

MR. PARKER: Yes.

Q I show you this. Is this the rule you are talking

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about, Rule No. 1107?

A That's right.

Q What does it say in the margin written?

A You mean "Change '72"?

Q Yes.

I don't believe that is what you testified to.

THE COURT: I didn't hear the answer. What is the answer?

THE WITNESS: It says, "Change '72."

Q That is not what you just testified to, is it? Didn't you say, if I remember correctly, that it was changed in '70 or '71?

A That's right.

Q What does that "Change 1972" mean?

A I beg your pardon. That is "Changed '72." It is not 1972, I am sure.

Q What does '72 mean?

A "Change '72" from what I gather.

Q Doesn't it mean 1972? What else can it possibly mean, Mr. Pascarelli?

THE COURT: That is arguing with the witness, isn't it?

Q What do you think "Change '72" means?

A I really don't know. I didn't write it.

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MR. PARKER: I am going to object to this whole line. We can simply put that into evidence.

THE COURT: I think you can put in how long it was effective. Why is there so much discussion?

MR. MURRAY: Because there is some question about when the rule was changed, your Honor.

Q Do you remember testifying in examination before trial at the hospital and I was present and Mr. Parker was present?

A Yes, I do.

Q On August 11, 1976?

A Right.

Q Do you remember being asked and answering if this rule was in effect on that day?

A Yes.

Q Do you remember what you answered?

A I didn't remember whether it was or it wasn't, if I am correct.

Q You are the administrator, right?

A That's what I am. I am not a walking encyclopedia.

THE COURT: Do I understand your testimony to be that that rule, the 90-day exclusion rule, was not in effect in the year 1972?

THE WITNESS: That 's right.

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1 Q When you testified on August 11, 1976 you
2 remembered the 90-day rule but you didn't remember if it
3 was in effect on that day.
4

5 A Right.

6 Q What was the basis of the finding out of your
7 knowledge that enabled you to testify today that it was
8 changed in -- what did you say, 1970 or '71? I don't
9 recall.

10 A Because of the changes that you told me to look
11 up. Not that one, you have got another change.

12 THE COURT: Gentlemen, there shouldn't be any
13 argument about this. Aren't these official records?

14 THE WITNESS: They are there, your Honor.

15 THE COURT: Will somebody introduce them in
16 proper form?

17 MR. MURRAY: I still don't see the proper record,
18 your Honor. I will if I see it. I am trying to find it.
19 That is the whole point of it.

20 THE COURT: Let the witness identify them,
21 please. Conduct the trial in an orderly way.

22 MR. PARKER: I show you this sheet first, that
23 is the '58, and then the change which is April 6, 1971.

24 MR. MURRAY: What are you showing me?

25 MR. PARKER: We can do this in short order if

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1 you will allow me.

2 Make these Defendants' Exhibit A for
3 identification.

4 THE COURT: You are offering it, are you not?

5 MR. PARKER: Well, yes.

6 THE COURT: What is Defendants' Exhibit A that
7 you are offering?

8 MR. PARKER: This is a page from the Veterans
9 Administration Manual titled M1 Part 1, Change 23
10 dated October 6, 1958. Under paragraph 1107, labeled
11 Periods of Exclusion From Hospital Treatments Domicillary
12 Care, Paragraph A is the 90-day rule to which we have
13 been referring. At the bottom in handwriting is the legend
14 "M1, Part 1 Change 1594/16/71."

15 On the left side of the page in handwriting, in
16 parenthesis, "CHG period '72." next to paragraph B.
17 Paragraph A, having no notation next to it being the
18 three-month rule.

19 Exhibit B is M1, Part 1 Change 159 dated
20 April 6, 1971.

21 The pertinent paragraph on this page is
22 paragraph 1106.

23 "Readmission of patients following irregular
24 discharge."
25

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2 If your Honor would like will read that into
3 the record.

4 THE COURT: You might as well read it into the
5 record.

6 MR. PARKER: "A patient who has received an
7 irregular discharge as provided in this section will
8 be authorized admission when he has satisfied the admitting
9 authority that he will conform to expected standards of
0 behavior. Care will be exercised to prevent an incriminatory
1 attitude merely to keep an applicant with a disciplinary
2 record from being admitted to the hospital."

3 I would offer these into evidence.

4 MR. MURRAY: I don't object to them, your Honor,
5 but I wish the Court to take into consideration the credi-
6 bility of the answer also the notation of '72 in the
7 margin.

8 THE COURT: Can I see them, please?

9 (Defendants' Exhibits A and B received
0 in evidence.)

1 Q Mr. Pascarelli, in the examination before trial
2 on August 11, 1976, were you asked the following
3 questions and did you give the following answers?

4 MR. PARKER: Could you give the page, please?

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MR. MURRAY: Sure. Page 10.

Line 18 on page 10:

"Q Was there a rule at that time if a patient signed himself out without advice he could not be readmitted for 90 days?

"A The rule was in existence but it was amended.

"Q I am talking about that date.

"A That date, I can't answer that. I really don't know if the rule applied."

Now on top of the page the date was given as 8/14/72. Page 10, the third line.

"Q So on that day you did not recall whether or not the rule applied to '72, is that correct?

A That's right. I didn't recall when the change was made and I told you this.

Q And you are the administrator of the hospital, is that right?

A That's right.

Q How was an admission attendant who was trained by you supposed to know which rule applied if you didn't recall it, sir, when questioned in 1976 about it?

A Very simple.

Q Yes?

A I have got 275 people.

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Q Right.

A I have subordinate supervisors.

Q Right. Who are under you, right?

A Who are under me.

THE COURT: Let him finish.

A Who do this daily. My job is not a clerk.

I am responsible for what my subordinate staff does.

This doesn't mean that I have to memorize every change, every manual, and let me tell you there are many, as to what date what change was made. This is left to my subordinate staff. I have a supervisor admissions, I have a section chief and I have an assistant. Down the line these people know what they are doing because they are doing it every day and they know these rules and regulations every day.

If I knew every rule and regulation that was on that book I would be a genius.

Q Is it not conceivable that the person in charge of admissions or behind the window or whatever might not have realized that this rule was amended, assuming it was amended in 1971, is it not possible that he might not have realized it was amended, with all the rules you have, which I understand are quite voluminous?

A I think I answered you it is possible.

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Q Is it not probable?

A Anything is probable.

Q In any event you did have this 90-day rule in effect as brought out by the evidence, is that correct?

A The 90-day rule was in effect until the day it was rescinded.

Q This meant when that rule was effective, that within 90-days there was a prohibition against a veteran from becoming readmitted unless he satisfied certain conditions simply because he signed himself out on an irregular discharge basis, is that correct?

A This is a decision that is a medical decision that is made. It is not an administrative decision.

Q I am talking about the rules, sir.

A The rules, yes.

Q Was it not your rule to have a doctor evaluate a patient coming on a mental complaint?

A It is the VA rule.

Q That is what I meant. I didn't mean you personally.

A You said me personally.

Q You are here as a representative of the Veterans Administration, are you not?

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2 A Yes.

3 Q Incidentally, you said that every patient
4 had a T -- what were those letters, temperature?
5 I believe you mentioned it to the Judge, do you recall?

6 A Yes. Temperature, pulse and respiration.

7 Q TPR or something like that?

8 A Yes.

9 Q You did this for every patient or every applicant
10 who came to the hospital?

11 A Almost every applicant.

12 Q What about a person like Mr. Cox that had a
13 mental complaint, you took his temperature immediately?

14 A We don't know he has a mental complaint.

15 Q Don't you ask him a question?

16 Isn't the procedure that the girl behind the
17 window or the man, whoever, asks him what he is there for?

18 A He is not feeling well. You don't say I want
19 to see a psychiatrist.

20 Q Suppose he says I have mental problems, I am
21 psychotic?

22 A We still refer him through the same channels.

23 Q You take his temperature?

24 A That is up to the nurse when she screens him.

25 Q So they don't necessarily take the temperature

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2 of every patient?

3 A I said that.

4 Q What is the procedure for a psychiatric patient?

5 A The same as for any other patient.

6 Q You take his temperature?

7 A That is still a decision that is medical not
8 mine.

9 Q What is the procedure when a psychiatric patient
10 comes back for readmission?

11 A The same as for any other patient.

12 Q Please tell me.

13 A He is processed. An application is made out and
14 he is referred to the nurse or the physician. The
15 physician evaluates him and refers him to the psychiatrist
16 if this is what he feels is required.

17 Q Is it not conceivable after hours when you are
18 a little bit less staffed than full staffed is you pointed
19 out that a former patient would come back either alone
20 or with a member of his family, present themselves at
21 the window, his record would be pulled and they would
22 say, "Sorry, your 90 days aren't up yet. you can't be
23 readmitted?"

24 A No. I don't think that would happen.

25 Q Could it happen?

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2 A Anything could happen.

3 Q So it is possible?

4 A Everything is possible.

5 THE COURT: This is argument, really.

6 A We went through this on that deposition. You
7 have got it all there.

8 Q The Judge wasn't present at the deposition, so
9 please bear with me.

0 You are the Director of the hospital, are you
1 not?

2 A No, I am not.

Q Assistant Director?

A No, I am not.

Q What is your title again?

A Chief Medical Administration Service.

Q To your knowledge is there any procedure where
an administrator or a director of the hospital can
ask for a commitment of a mental patient prior to his
being released?

A That is a medical determination, not the
administrator or the director.

Q Assuming that you receive such a medical
determination from your staff, is there --

A It wouldn't be from my staff --

Q Let me finish the question if you don't mind.

Assuming there is such a medical determination from your staff, is there a procedure that you can follow to have such a patient committed?

A Yes.

Q Would you please tell the Court what that procedure was in 1972?

A The same as it is today. A two-physician certificate.

Q A what?

A You do it on a two-physician certificate to a state institution.

THE COURT: That is under New York State law?

THE WITNESS: That is under New York State law, your Honor. That is if the physicians feel the man is a danger to himself and others, he is asking for his release, they feel he should not be released, they will contact the family first to have the family commit him on their signature. If they refuse and our medical staff still feels that he should be committed, that he needs this for his well being and others, then we can do it on a two-physician certificate through the State Department, which we handle through Manhattan State Hospital, your Honor, which is in our jurisdiction.

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Q Has this ever been done?

A Yes, it has.

Q And it should be done in a case where you receive a medical determination that you hold a certain patient, is that correct?

A Correct.

Q Was this ever discussed to your knowledge with either the mother Mary Cox or the sister?

A They would not discuss it with me.

Q I beg your pardon?

A They would not discuss it with me.

Q Who is they?

A Who you said.

Q Why don't you let me finish the question first.

Did you or anybody in the administration staff ever discuss with either Mrs. Mary Cox or her daughter, who is the sister of the decedent, also named Mary Cox, the advisability of a commitment in this case because of the treatment that he did not have completed?

A I never did.

Q Are there any records at the hospital that you are aware of?

A There are no records.

Q In the same examination I refer to page 25 and

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2 page 26. Line 17:

3 "Q What were those regulations in effect in August
4 and September of 1972?

5 "A This is on irregular discharge hospital patients.
6 The classes of patients listed below will be given
7 irregular discharges. The staff physician will enter
8 a notation on SF 509 progress notes explaining a patient's
9 reason for leaving the hospital when the departure is
10 not medically approved. The notation will be supported
11 by a brief statement of the patient's condition. A,
12 patients who refuse, neglect or obstruct care and
13 treatment. B, who refuse to accept transfer as outlined
14 in Chapter 11. C, patients who fail to return from
15 authorized absences and patients who leave hospital
16 supervision without approval of their physicians.

17 "These are the exceptions. Patients considered
18 unable to make adequate judgment about their best
19 interest or who are committed or who have institutional
20 awards will be placed on absence as provided in Chapter
21 10 or placed on non-bed care or out-patient care."

22 Does that refresh your recollection? Did you
23 answer that question in that way?

24 A I read that out of the manual, I think Mr. Parker
25 has a copy of the manual, M1 Part 1.

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2 MR. PARKER: I have a copy of that section.
3 Mr. Murray, if you would like to put that in evidence
4 why don't you do that?

5 MR. MURRAY: I would like to do that with
6 particular note to his Honor of patient was considered
7 unable to make an adequate judgment of their best
8 interests is an exception to the irregular discharge rule
9 to be used.

10 (Plaintiffs' Exhibit 4 received in
11 evidence.)

xx

12 THE COURT: All right.

13 Q So in that rule, Mr. Pascarelli, there was an
14 exception. In other words, a patient was not permitted
15 to have an irregular discharge if there was a medical
16 determination given to you that a patient was considered
17 unable to make an adequate judgment about his best
18 interest, is that correct, sir?

19 A Read that again. Given to me? They don't give
20 it to me. The medical determination is made by a physician --

21 Q I understand that. I didn't ask you to make
22 a medical determination.

23 A You said do they give it to me. Read it again.

24 MR. MURRAY: Do you want to read back the
25 question, please.

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(Record read.)

A I object to given to me.

Q You object to what, sir?

A To that given to me. It is not given to me.

The physician writes it into the chart. It is something that they do. I don't do it.

Q I understand that.

A This is my point. This is why I asked.

Q Assuming a physician was of the opinion -- and let me read that again.

THE COURT: I assume the patient couldn't sign himself out if the physician felt he was mentally incompetent, isn't that it?

THE WITNESS: Then we wouldn't let him out.

MR. MURRAY: The words are if he is unable to make --

THE COURT: You read the words in, but it is perfectly clear what it means.

Q Did you also testify on page 13 -- let's see where it starts. Page 12 the question starts, line 18 from the same examination.

"MR. PARKER: Let me see if I understand the question. Is the question in August of 1972 was there a particular procedure in effect in regard to the

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2 discharge of depressed patients, is that your question?
3 "MR. MURRAY: Who wanted to sign themselves
4 out, yes.
5 "MR. PARKER: Can you answer that?"
6 Next page, 13:
7 "A I can't answer it because I am not medically
8 qualified to answer that of his condition, whether he
9 was or wasn't.
10 "MR. PARKER: Not as to Mr. Cox, but in general.
11 "A If he was depressed so that a physician felt
12 his discharge would be detrimental we would not discharge
13 him until the family was called and arrangements were
14 made for his treatment elsewhere if he refused to stay
15 there."
16 Is that the sum and substance of your answer,
17 sir?
18 A That was it.
19 Q Was that the rule at that time?
20 A That is always the rule.
21 Q Do you know if the Cox family was called to make
22 arrangements to have him treated afterwards before he
23 was allowed to have an irregular discharge on or about
24 August 14, 1972?
25 A I can't answer that because I don't know what

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2 that you want to develop you may resort to your deposition.

3 MR. MURRAY: All right, fine.

4 Q Did you or did you not examine the hospital
5 records before coming here today to see if the Cox family
6 was notified to have him treated elsewhere prior to his
7 irregular discharge on August 14, 1972?8 MR. PARKER: I am going to object on the grounds
9 of relevancy. The hospital records are in evidence.

10 THE COURT: They speak for themselves I assume.

11 MR. PARKER: Of course.

12 MR. MURRAY: The hospital records don't indicate
13 that, your Honor.14 THE COURT: Then you will confirm it at the
15 appropriate time.16 Q Are there any other records that you have in
17 your office about contacting families of patients other
18 than what is in the hospital record?

19 A No, I don't.

20 Q You don't keep any log or memorandums?

21 A No, sir.

22 Q Does the director keep any records that you
23 are aware of?

24 A No, sir.

25 Q Did you ever determine what employee was on

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2 duty on September 20, 1972 at about 5:30 in the evening
3 in the admissions area?

4 A No, I haven't.

5 Q Were you not supplied with a photograph by
6 your attorney, Mr. Parker, to help such identification of
7 the decedent?

8 A Yes, I had.

9 Q Did you show it to the various employees that
10 might have been on duty?

11 A I showed it to the employees who were on my
12 staff at that time.

13 Q Are many of them still on your staff or have
14 some come and gone in the meantime?

15 A I think I have got five of my staff are still
16 with me who were with me in '72.

17 Q How large is the staff, sir?

18 A 36.

19 Q And those five could not identify Mr. Cox?

20 A No.

21 Q As having come on September 20, 1972?

22 A Right.

23 MR. MURRAY: I have no further questions, your
24 Honor.

25 THE COURT: Any redirect?

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MR. PARKER: Just one question.

REDIRECT EXAMINATION

BY MR. PARKER:

Q Mr. Pascarelli, does the administrative service of the hospital play any role in making decisions as to civil commitment of patients?

A No.

Q As to the discharge of patients?

A No.

Q Who does that?

A That is a medical decision.

MR. PARKER: No further questions.

THE COURT: All right, you may step down.

MR. MURRAY: Just one question.

RE CROSS EXAMINATION

BY MR. MURRAY:

Q But the medical decision would come to the administrative office, is that correct, if it reached that point?

A The medical decision is made by the physician. It is written into the record and the man is discharged. We don't know --

Q No.

THE COURT: Let him finish, won't you please?

1 rgrf

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2 I am trying to hear the answer.

3 A We don't get involved in the reasons for dis-
4 charging unless the physician contacts us for administrative
5 assistance in resolving problems and what procedure
6 to handle it.

7 Q But I was trying to ask the other question, sir.
8 I didn't mean to interrupt you. Assuming the doctor
9 feels the patient should be held or committed or the
10 family brought in to commit him or whatever, is it not then
11 brought to the administration's attention?

12 A When the procedure has been completed on the
13 treatment area, which is the two-physician certificate
14 or the memorandum, with the people that were contacted,
15 the physicians contacted at Manhattan State Hospital,
16 the acceptance state of the patient, then we get
17 involved in transporting the patient over.

18 Q So you are called in at that point with a civil
19 commitment?

20 A After it is completed.

Q Whose responsibility is it to contact the family?

A The physician.

23 Q If they are contemplating a civil commitment?

24 A The physician does.

25 MR. MURRAY: Thank you.

1
2 MR. PARKER: I'm sorry, your Honor, but I
3 really think for purposes of clarity one additional
4 question should be asked.

5 REDIRECT EXAMINATION

6 BY MR. PARKER:

7 Q Mr. Pascarelli, would every note made regarding
8 the treatment of a patient be in his hospital record?

9 A Yes.

10 Q If a remark by a physician is reduced to writing
11 it would be in no other package but the hospital record,
12 is that correct?

13 A The hospital record, right.

14 Q So in other words, Plaintiffs' Exhibit 1,
15 Mr. Cox's hospital record, would have all medical
16 comments that were reduced to writing about Mr. Cox and
17 you wouldn't have them anywhere else?

18 A Nowhere else but in the medical record.

19 MR. PARKER: Thank you.

20 THE COURT: You are excused.

21 MR. MURRAY: Just one other question if you
22 don't mind.

23 RECROSS EXAMINATION

24 BY MR. MURRAY:

25 Q If there was no evaluation by a doctor of an

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2 applicant, that would be in violation of the hospital
3 rules, is that correct?

4 MR. PARKER: I am going to object to that.

5 MR. MURRAY: Read it back.

6 THE COURT: Don't read it back. Put your
7 question again.

8 Q If there were no evaluation of a patient who
9 came into the hospital to be treated by a doctor, would
10 that be in violation of the hospital rules?

11 MR. PARKER: I withdraw my objection. I just
12 didn't understand the question.

13 A I don't follow you.

14 THE COURT: Do you understand the question?

15 THE WITNESS: If he walked in and walked out
16 we have no responsibility.

17 Q He walked into the admissions area and made
18 a complaint and if he were not then evaluated by a doctor,
19 would that be a violation of the hospital rules?

20 A If we had a record and he was not seen or
21 was refused to be seen, then it would be a violation.

22 MR. MURRAY: Thank you, sir.

23 THE COURT: All right.

24 (Witness excused.)

25 THE COURT: Let me see the hospital record.

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2 MR. MURRAY: We made a demand and Mr. Parker
3 indicates they made a search and could not find such
4 an entry, is that correct?

5 THE COURT: The entry would be on the chart.

6 MR. MURRAY: There is no such entry.

7 MR. PARKER: In other words, your Honor, this
8 is the Manhattan Hospital record. If there was anything
9 for that date it would be there. As a matter of hospital
10 practices I think your Honor might have gathered from
11 Mr. Pascarelli's testimony, if Mr. Cox had come to the
12 hospital on the 20th of September the records found there
13 would have been a 1010M, that is the medical certificate
14 which would be signed by a physician or possibly a form
15 1010, which is an application for admission which would
16 be signed by the applicant, in this case Mr. Cox.

17 MR. MURRAY: That is assuming procedure was
18 followed, your Honor.

19 MR. PARKER: Of course. That is the hospital
20 procedure.

21 THE COURT: All right.

22 MR. MURRAY: And as indicated, we made every
23 effort to find the employee that was on duty that evening.
24 31 out of 36 are no longer with the hospital, as established
25 by Mr. Pascarelli, but we made every effort to get to

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2 the bottom of it. A photograph was supplied of the late
3 Mr. Cox for that purpose and extensive depositions
4 were taken.

5 THE COURT: Recall the witness. I want to ask
6 him a question.

7 MR. PARKER: The Government recalls Mr. Pascarelli.
8 P E T E R A. P A S C A R E L L I, recalled
9 to the stand, having been previously duly sworn,
10 testified further as follows:

11 EXAMINATION BY THE COURT:

12 Q If a veteran had appeared on September 20,
13 1972 and applied for readmission, would any record be made
14 of that?

15 A Yes, sir.

16 Q What record would be made?

17 A We would make out a routing sheet, which is our
18 count that we maintained for our cost and also the 10M,
19 the medical certificate, which would be forwarded to
20 the physician to make his evaluation of the patient.
21 In the interim we would call for his record. The 10M
22 would then be placed in his record.

23 Q What is the 10M?

24 A The 10M is the medical certificate on the
25 examination. There is a copy in the record right now

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2 for his '72 admission.

3 Q Would that be made out automatically?

4 A That is made out automatically.

5 Q Without regard to subsequent events?

6 A Right.

7 Q The minute the veteran appears --

8 A It is made out.

9 Q A clerk or an administrative assistant makes out
10 this form?

11 A Right.

12 Q Would there be any circumstance in which a
13 clerk would not make out the form?14 A Anything is possible, but I doubt it. We make
15 them out, your Honor, where -- you know, we get
16 chronic alcoholics come into our institution, especially
17 on the off hours. When I come in in the morning I read
18 my reports and I walk out and I go look at the application
19 and my clerk will write on the medical certificate
20 the patient did not wait for examination and the physician
21 will put the time that he called him and sign it so
22 that we keep these in the file just in case something
23 does happen. This is a recurring thing.

24 Q You say the normal practice is whoever appears --

25 A We make it out.

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2 Q You don't know and the clerk doesn't know whether
3 the individual is a veteran or nonveteran, that form is
4 still made out.

5 A We ask if he is a veteran and we make it out.
6 If he is a nonveteran, no matter what time, and he is
7 having problems, we let the physician make a decision
8 whether he can walk up to Bellevue, NYU, or whether we
9 should give him emergency treatment and then move him,
10 but we do maintain these records.

11 THE COURT: All 'right, you are excused.

12 MR. PARKER: May I just ask one question.

13 FURTHER DIRECT EXAMINATION

14 BY MR. PARKER:

15 Q This routing slip that you referred to, how long
16 is that kept?

17 A 90 days.

18 FURTHER CROSS EXAMINATION

19 BY MR. MURRAY:

20 Q After 90 days this record is thrown away?

21 A The routing sheet is disposed of.

22 Q So if there was such a routing sheet filled out --

23 A We won't have it.

24 Q In any event it is possible --

25 THE COURT: You ask that a half dozen times and

1 rgrf

2 Mary Cox etc.,

3 vs

75 Civ. 3226

4 Administrator of the Veterans
5 Administration, et al.

6 New York, New York
7 December 10, 1976 10:30 a.m.

8 (Trial resumed.)

9 THE COURT: Good morning all.

10 Proceed, please.

11 MR. PARKER: The Government calls Dr. Martin
12 Kesselman.

13 M A R T I N K E S S E L M A N, called as
14 a witness by the Government, being first duly sworn,
15 testified as follows:

16 MR. PARKER: May I proceed?

17 THE COURT: Yes.

18 DIRECT EXAMINATION

19 BY MR. PARKER:

20 Q Dr. Kesselman, are you a physician duly licensed
21 to practice medicine in the State of New York?

22 A Yes, I am.

23 Q For how many years have you been practicing
24 medicine?

25 A For 16 years.

Q In the course of those years have you specialized

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1 in any branch of medicine?

2 A Yes. psychiatry.

3 Q Are you certified by any board?

4 A Yes. I am certified by the American Board of
5 Psychiatry and Neurology.

6 Q When were you certified?

7 A In 1973.

8 Q Doctor, will you please tell us what your medical
9 training and experience has been?

10 A Yes. I received my medical degree from the State
11 University of New York, Downstate Medical Center in 1960.
12 I had attended it from 1956 to 1960. From 1960 to 1971
13 I served my internship at St. Louis Children's Hospital
14 in St. Louis, Missouri.

15 After a period of time, from 1961 to 1965,
16 as a captin in the U.S. Air Force Medical Corps, I
17 returned to my training at NYU Bellevue Medical Center
18 where I took a three-year psychiatry residency from
19 1963 to 1966. The last year of my training overlapped
20 with a two-year research fellowship which terminated
21 my formal training in 1967. That was also obtained at
22 NYU Bellevue Medical Center.

23 Would you like me to give my professional
24 experience after that?
25

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Q Yes. Would you please.

3

A Certainly.

4

From 1967 to 1973 I was on the attending staff of Bellevue Hospital, the psychiatric division, and on the psychiatric staff of NYU University Hospital.

7

In 1973 I assumed my present position as the chief of the psychiatry service at the New York VA Hospital.

9

Q Doctor, have you held any academic appointments?

10

A Yes, I have. In 1967 I was appointed as instructor in the department of psychiatry at NYU Medical School. I retained that title for two years until 1969 when I was promoted to assistant professor in the same department.

14

In 1973 I was promoted to my present position which is associate professor of clinical psychiatry.

16

Q Can you tell us some of your teaching responsibilities.

17

18

A During the time I was an instructor and assistant professor I served as the coordinator of the undergraduate teaching program in psychiatry. Toward the latter part of that period, and also during the time I have been at the VA, I have also taught a seminar in schizophrenia for the psychiatry residents in the program.

19

20

21

22

23

24

Q Doctor, have you engaged in any research activities?

25

A Yes, I have. When I came to the VA I was awarded

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2 a research grant to do research in recognition, which was
3 essentially memory and learning mechanisms in schizophrenia.
4 Our efforts were to try to understand some of the
5 mechanisms which led to the unusual thinking that
6 characterizes patients with schizophrenia.

7 Q Doctor, have you published any writings?

8 A Yes. I have published seven articles. Some of
9 them have been in the area I just described to you. I
10 have also published a couple of articles on manifestations
11 of psychiatric illness in bilingual patients and I have
12 published some articles on complications of drug
13 treatment in schizophrenia.

14 Q Doctor, I show you Plaintiffs' Exhibit 1 and
15 2 which are the hospital records of Bobby Cox, the
16 decedent in this case, No. 1 being from the Manhattan
17 Veterans Administration and No. 2 being from the
18 Fayetteville, North Carolina Veterans Administration
19 Hospital.

20 Have you reviewed those records?

21 A Yes, I have.

22 Q Doctor, what factors does a psychiatrist look
23 to in determining whether a patient is an imminent
24 suicide?

25 A That is a very difficult decision in many

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1 but not all cases. Let me divide the criteria one would
2 want to look for into three groups. Perhaps in the
3 simplest and most extreme cases the patient will tell
4 the psychiatrist or a person in the hospital setting
5 off such an intention. He may do it directly. He may
6 do it by announcing it to somebody else who then brings
7 it to the attention of the treating person. At that
8 point the psychiatrist has the responsibility of
9 determining how seriously the patient is harboring such
10 thoughts, whether he has initiated any plans to carry
11 through such an action and to make a judgment about the
12 safety that the patient's environment would provide in
13 view of his findings.
14

15 Unfortunately not all cases are quite so simple.
16 That is some patient's will not directly talk of suicidal
17 intentions. In that case the psychiatrist has to take
18 two other classes of data into account.

19 One is that he knows from his own clinical
20 experience and that of other people that in certain illnesses
21 there is a predisposition toward suicidal behavior
22 which certainly must increase his index or suspicion.
23 Perhaps the most dangerous illness in this respect is
24 depression and perhaps particularly so-called endogenous
25 depression. These are depressions of a so-called manic

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2 depressive sort and may include the kinds of involuntional
3 melancholias that people see in the 40 to 60 year old
4 age group, a particularly dangerous group of depressions
5 in terms of suicidal risk.

6 A second group of illness is one which must raise
7 one's index or suspicion is the group of schizophrenias.
8 Again the fact that a patient has schizophrenia doesn't
9 mean that he is suicidal or suicidal all the time, but
10 the doctor has the obligation to take that diagnosis
11 into account.

12 Certain patients in certain kinds of confused
13 states, for instance delirious patients, on account of
14 their delirium may not be able to exercise certain
15 kinds of judgment as to the safety of their actions.

16 That is a man may for instance try to escape
17 from hallucinative persecutors by jumping out of a window
18 without being able to ascertain the fact that the window
19 is on a high floor.

20 Unfortunately, when one takes the diagnosis
21 into account and it is far from a clinching piece of
22 evidence, one has to take a third group of factors
23 into account. Those are what I would call precipitating
24 factors. That is even if there were some reasons to
25 feel the patient may be predisposed at least at certain

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2 times in his life to suicide, one also has to take
3 into account whether at the particular time of evaluation
4 the patient is under stress.

5 Perhaps because of the loss of a significant
6 person in his life. Perhaps because of a major disappointment.
7 Perhaps because of physical illness. Perhaps because
8 of a frustration in terms of some of his particular
9 ambitions or hopes.

10 At those times, just by I think common sense,
11 one would recognize that a patient may be more vulnerable
12 to considering suicide as a way of expressing either his
13 need for help or his hopelessness and one has to evaluate
14 the special circumstances in each patient.

15 Finally, I think I would have to say that I
16 know of no area of psychiatry in which both science
17 and art have to combine to make a very difficult kind
18 of assessment and that there is no area I can think of
19 which is so unlikely to be guided by pure rules
20 or let's say clinical maxims.

21 Q Doctor, turning to Mr. Cox, based on your
22 review of the hospital record, do you have an opinion
23 from a medical point of view as to whether in the light
24 of accepted medical practices the VA Hospitals in Manhattan
25 and Fayetteville acted unreasonably in permitting

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Mr. Cox to sign out against medical advice?

MR. MURRAY: I would like to object to that question because there are two questions in one. He is asking two different areas, your Honor.

THE COURT: Separate them with respect to each.

MR. PARKER: Yes.

Q Let us begin with the Manhattan Hospital.

Do you have an opinion?

A Yes, I do.

Q What is that opinion?

A My opinion is that he did not act unreasonably.

Q Can you tell us the basis for your opinion?

A Yes. I think that a reasonable standard of performance for a hospital in this situation is to have achieved a degree of information or understanding of the patient, both in terms of diagnosis and his current mental state, to have allowed themselves to have assessed both suicidal risk and an appropriate course of treatment. I think that in the hospitalization that you are describing, that that goal was met.

The diagnosis it seems to me seems to be well founded. The chart documents that the patient had been observed and that a proper and appropriate amount of information was available. The treatment it

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2 seems to me seems to be suitable to the diagnosis and
3 the information recorded in the chart and the decision
4 to allow the patient to be dischaarged AMA seems to me
5 to have been based on an adequate standard of professional
6 action and judgment.

7 Q Turning to the Fayetteville Hospital, would you
8 like me to repeat the question or do you recall it?

9 A I recall it.

10 Q Okay. Well, then, do you have an opinion?

11 A The amount of information available to me there
12 is based of course on the chart. My opinion, based on
13 the information in the chart, is that that hospital,
14 too, had not acted unreasonably in allowing Mr. Cox
15 to be discharged.

16 MR. MURRAY: Your Honor, I would like to voir
17 dire the doctor to find out if he is familiar with what
18 the standard is down in North Carolina?

19 MR. PARKER: I will be very happy to ask that
20 question.

21 Q Dr. Kesselman, are you familiar with the
22 medical standards for treating schizophrenic patients
23 throughout the United States?

24 A Yes, I am.

25 Q Do they differ from those here in New York City?

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1 A No, they do not. Not in a VA Hospital certainly.

2 Q In other hospitals?

3 A I am not familiar with other hospitals.

4 Q You have given your opinion.

5 MR. PARKER: Mr. Murray, do you have an
6 objection?

7 MR. MURRAY: No, I don't.

8 Q Again would you give us the basis of your
9 opinion in regard to the Fayetteville Hospital?

10 A The patient, according to the record, presented
11 himself for treatment. There was an assessment that he
12 required hospitalization and a correct diagnosis was
13 entered at the time of his admission. The chart records
14 the fact that he was seen by a qualified psychiatrist
15 and the information about the patient's mental state
16 certainly seems to be in accord with the information
17 previously entered.

18 The treatment that he received was in accord
19 with good standard treatment practice for this diagnosis
20 and there was no citation of any evidence to suggest
21 that the patient was imminently suicidal or homicidal.

22 Therefore, I think that one can reasonably
23 say that the patient was treated with a proper degree--
24 you know, with a proper treatment down south.
25

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Q Doctor, again based on your review of Mr. Cox's hospital records, do you have an opinion from a medical point of view as to whether the Veterans Administration physicians who saw Mr. Cox at the Manhattan Hospital in the application of accepted medical practices should have anticipated that he was likely to commit suicide?

A Yes. I have an opinion.

Q What is your opinion?

A I see nothing on 'the chart to lead me to believe they should have anticipated that this patient was in imminent danger of suicide or committing suicide.

Q Now turning to the Fayetteville VA, there do you have an opinion as to whether or not the physicians who saw Mr. Cox in the application of accepted medical practices should have anticipated that he was likely to commit suicide if he discharged himself against medical advice?

A I have to be guided by the information available to me. On the basis of that I see no indication that the physicians could have been aware that Mr. Cox was imminently suicidal.

Q Please assume that after the Fayetteville hospitalization which ended on August 21, 1972 that Mr.

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1 Cox attempted to gain admission to the Manhattan Veterans
2 Administration Hospital on September 20, 1972 and please
3 further assume that he was refused admission by an
4 admissions clerk. Based upon the hospital records for
5 both hospitals can you form an opinion with a
6 reasonable degree of medical certainty that this
7 assumed sequence of events was a precipitating cause
8 of Mr. Cox's suicide on October 11, 1972?
9

10 MR. MURRAY: I would like to object to that
11 question because the doctor, I believe, as is obvious,
12 has never seen Mr. Cox, is that correct?

13 THE WITNESS: That is correct.

14 MR. MURRAY: There is no record of the
15 admission submitted by the Veterans Administration of
16 September 20, 1972 of a medical evaluation and therefore
17 I must object to the question. I cannot see how
18 an expert without an evaluation of the patient can make
19 such a judgment.

20 THE COURT: He is basing it on testimony in the
21 case.

22 MR. MURRAY: No, he is basing it I believe on
23 hospital records which are not in existence, at least
24 the VA has not produced them.

25 MR. PARKER: Perhaps I was unclear in the question.

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2 Mr. Murray.

3 THE COURT: Put your question again. It is clear
4 to me, but put it again.

5 MR. PARKER: Perhaps the reporter could read it.

6 THE COURT: No, rephrase it so we will save
7 time.

8 Q Doctor, please assume that after Mr. Cox's
9 discharge from the Fayetteville Veterans Administration
10 Hospital, which occurred on August 21, 1972, Mr. Cox
11 attempted to gain admission to the Manhattan Veterans
12 Administration Hospital on September 29, 1972. Please
13 further assume that he was refused admission by an
14 admissions clerk.

15 Now, then, based upon your review of the
16 hospital records, Plaintiffs' Exhibit 1 and 2 in evidence,
17 can you form an opinion with a reasonable degree of
18 medical certainty that this assumed sequence of
19 events was a precipitating cause of Mr. Cox's suicide
20 on October 11, 1972?

21 A No, I cannot. I would need more information.

22 Q What information would you need?

23 A As I mentioned in my response to the first
24 question, I think the evaluation of suicide or potential
25 suicide is fraught with difficulty; even when one has

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1 an event contiguous in time with the suicidal behavior,
2 let's say an argument after which the patient commits
3 suicide. It might be very hard to establish a causal
4 connection. In this case there was I believe a three-
5 week period between your hypothetical date and the actual
6 suicide.
7

8 Secondly, your question doesn't really give me
9 any information about the patient's mental state during
10 the period of time he was presumed or alleged to have
11 come into the hospital in your example.
12

13 I would suppose that if the patient were in
14 an imminently suicidal state of mind and he had been
15 refused admission and the family was sufficiently
16 distraught and lacking resources so that they were fragmented
17 and thrown into a kind of helpless state, allowing for
18 all those things one might conceive that there might
19 be a connection between your hypothetical example and
20 what happened three weeks afterwards.
21

22 On the other hand, obviously there is a very severe--
23 this man was severely ill with an illness in which the
24 threat of suicide must always be considered and in
25 which the danger of suicide does have a fluctuating
course, so it is quite conceivable even if the man was
suicidal when he came in, that he might have been less

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2 suicidal a day or two later. We are dealing with a
3 disease which is in some ways so unpredictable in terms
4 of its course that it would be very difficult on the
5 basis of the information that you give me to do anything
6 more than begin to orient my thinking.

7 Certainly without further information I couldn't
8 reach a final conclusion.

9 THE COURT: You need further information as to
10 what?

11 THE WITNESS: I would like to know, in this
12 hypothetical example, what was his mental state at the
13 time? Obviously we don't have it by the definition
14 of the question.

15 THE COURT: According to the testimony he returned
16 to New York on September 19, 1972, that is from Fayetteville,
17 and according to his sister he seemed like he needed
18 medical attention. He said that is why he had come back.

19 The sister went with him the next day to the
20 hospital at 23rd Street to get medical attention.
21 According to her testimony that is the assumption,
22 although the Government doesn't concede the fact that
23 he was refused admittance because of the 90-day exclusion
24 rule.

25 Does that aid you in any respect?

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2 THE WITNESS: No, your Honor. It wouldn't aid
3 me because we are dealing with a disease which fluctuates
4 so intensely that to make -- to assume that whatever
5 suicidal impact or suicidal state of mind the patient
6 was put into on account of being turned away, we would
7 have to assume that it was sustained for three weeks
8 without the family's having recourse to return to the
9 hospital or any other facility.

10 THE COURT: There is no evidence as to that
11 as I recall it.

12 Then I take it you have no opinion you can state
13 with reasonable medical certainty as to causal relation-
14 ship.

15 THE WITNESS: That is correct.

16 MR. PARKER: I have no further questions, your
17 Honor.

18 CROSS EXAMINATION

19 BY MR. MURRAY:

20 Q Doctor, suppose I tell you that the sister
21 testified that he was very depressed. Would that help
22 you in your evaluation? On that date, now, September 20th.

23 A On September 20th?

24 Q Yes?

25 A No.

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1 THE COURT: Actually the testimony was that she
2 felt he needed to come in the hospital and he was getting
3 depressed again. It is a little different from what you
4 said.
5

6 MR. MURRAY: If I misquoted, I'm sorry, your
7 Honor. That was my recollection, that she used the
8 word depressed.

9 THE COURT: Would that make any difference in
10 your answer?

11 THE WITNESS: We are dealing with matters of
12 degrees. If for instance the question were phrased
13 as the patient was depressed or was very depressed, I
14 would still want to know if the patient was suicidal
15 because many people are depressed without being suicidal
16 and, secondly, I would want to know whether that
17 depression was in fact sustained over the intervening
18 interval or as is not uncommon in these cases, whether
19 it fluctuated.

20 If he was getting depressed, of course, that
21 would weaken, you know, the first of that consideration.

22 THE COURT: Assume further that the sister testi-
23 fied that her brother, the decedent, never threatened
24 suicide or attempted to harm himself or her in her
25 presence. The only violent incident that she testified
to was that he once pulled the phone off the wall.

1 THE WITNESS: I think that that would certainly
2 make me very reluctant to assume a strong causal
3 relationship between this hypothetical visit on
4 the 20th and the subject act.
5

6 Q Assume further that his mother testified that
7 he talked about suicide and asked her for the whereabouts
8 of her gun. How would these factors --

9 THE COURT: Fix the time as to that, though.

10 MR. MURRAY: I believe the mother said that
11 it happened -- I don't remember the exact testimony,
12 but I believe the mother said that it happened from time
13 to time. I don't recall her exact testimony. Maybe
14 we should have the record read back.

15 THE COURT: I don't believe she saw him after
16 August 20th or August 21, 1972.

17 MR. MURRAY: He was back down in North Carolina,
18 your Honor. I believe he went back.

19 MR. PARKER: If I may interject, your Honor
20 is referring to the period between August 21st
21 and September 20th.

22 THE COURT: The counsel may want to enlarge
23 it to include another period, too.

24 MR. MURRAY: That's right.

25 Q Assume the mother testified to that, that
although she perhaps could not fix an exact date,

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1 but assume that the mother testified, just for your
2 hypothetical in any event, that the inference could be
3 made that the son, the decedent, Bobby Cox, the former
4 patient herein, that he mentioned suicide and asked for
5 the whereabouts of her gun.
6

7 How would that affect your thinking, Doctor?

8 A When are we assuming this took place?

9 Q Within that period. We are not certain as to
10 the exact date.

11 MR. PARKER: Within which period?

12 MR. MURRAY: For the purpose of the hypothetical,
13 August 21, 1972 to September 20, 1972.

14 MR. PARKER: I have got to object to that, your
15 Honor. That is just impossible based on the testimony.
16 It has to be before -- I'm sorry, I withdraw my objection.

17 A I now understand the period, but could you repeat
18 the question.

19 Q Sure.

20 Do you want to read that back, please.

21 (Record read.)

22 A Thinking about what?

23 Q About the connection, the causal connection
24 between suicide and the failure to admit him in September
25 20, 1972.

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2 A I think this patient committed suicide because
3 he was schizophrenic and because he was a man who was
4 in great mental pain. Schizophrenics show a very
5 irregular course. The threat of suicide is always there.
6 If what you are saying is that there was evidence that
7 the patient had expressed sometime during this period
8 suicidal ideation, I think that would certainly be
9 consistent with a patient who may at times have been
10 in despair because of his illness. I find it difficult,
11 because of the -- you know, the very unpredictable nature
12 of the illness to describe an earlier -- between earlier
13 suicidal ideation and frank gesture later on because
14 I don't know what the patient's mental state was more
15 proximally to the actual gesture.

16 He may have stopped being suicidal for a long
17 period of time between that.

18 THE COURT: Doctor, you used the expression
19 schizophrenia several times. What is your definition
20 of it?

21 THE WITNESS: It is a difficult definition.
22 It is a difficult syndrome or illness to define. It
23 is generally considered to be a disease or a group of
24 diseases, we can't yet distinguish, characterized
25 by disturbances in anything, in mood and in behavior.

2 The thinking is very characteristic. The
3 patient very often uses metaphors as reality. For instance,
4 if he says I have butterflies in my stomach, he may
5 then go on to say I can't open my mouth or they will
6 fly out. That is called concreteness.

7 This thinking process may move not in the way,
8 let's say, people do when they are using ordinary,
9 Aristotlian logic, but may proceed in illogical or unusual
10 ways so that the patient may say something like, I am a
11 man. Socrates is a man, so I am Socrates, which of
12 course violates ordinary logic.

13 The patient's thought processes may be intruded
14 upon by idiosyncratic or highly symbolic kinds of
15 thinking so that, for instance, in the case of this
16 patient, in 1968 at one point he said, "My mother is dead."

17 In a patient with schizophrenia one might wonder
18 if in fact in a metafarcial way if he didn't feel in
19 fact his mother was dead rather than in a literal way,
20 but of course it is very hard for people assessing the
21 patient to reach such a conclusion.

22 Disturbances in mood or emotion are far easier
23 to demonstrate and to convey. Generally they fall in
24 two broad categories. One is an absence of the ordinary
25 kinds of moods so that the patient may seem to be

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2 emotionless. In situations where people have very
3 strong reactions, or his mood may seem inappropriate.
4 For instance, on hearing that his relative has died,
5 he may smile instead of cry or hearing a joke he may
6 burst into tears. Sometimes all one sees is storminess
7 or impulsivity so that the patient may be calm for
8 long periods of time and suddenly bursts into a violent
9 anger or into a severe depression for no reasons that
10 is perceptible to an outside person.

11 THE COURT: Are expressions of suicidal
12 purpose common in the case of a schizophrenia?

13 THE WITNESS: Yes, they are, your Honor.
14 Schizophrenics express thoughts or suicide not uncommonly
15 and the suicide rate amongst schizophrenics is higher
16 than the general population.

17 Q Doctor, I realize you never examined Mr. Cox
18 and I am doing the best I can to frame these questions.

19 A Of course.

20 Q Let's assume, and I believe Mr. Parker also
21 gave you this hypothetical -- of course you read the
22 record and he was released on August 21st from Fayetteville.
23 That is the last hospital record we have, although there
24 was testimony that there were several attempts at
25 getting into various hospitals. In any event, taking

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1 that hypothetical that Mr. Parker gave you that Mr.
2 Cox presented himself at the Veterans Administration
3 Hospital on or about September 20, 1972 with his sister,
4 his sister had testified to that effect. Assuming
5 that in your hypothetical, that that is the case, that
6 they came to a window at an admissions office or
7 whatever and some sort of clerk who came to the window
8 and asked his name or social security number or other
9 identifying information, whatever, and said sit down.
10

11 They waited and then the records arrived sometime
12 after, she wasn't clear as to just how long it took, but
13 they sat in the waiting room for a while as people do going
14 into hospitals.

15 In any event, this clerk called them back and
16 said, "I'm sorry, you signed yourself AMA, as you know from
17 the New York Hospital, less than 90 days ago and we have
18 a rule that you can't be readmitted."

19 When she balked about it, when she told him
20 about the fact that her brother was depressed, the person
21 behind the window said, "Rules are rules."

22 Let's assume further that this person is not
23 a doctor. Let's assume there was no evaluation or medical
24 examination. Do you think with your eminent qualifications
25 that this is following accepted medical practices and

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2 standards in the Manhattan Hospital?

3 A Absolutely not.

4 Q Is it not very likely with a history of
5 schizophrenia like this man had that he might have been
6 at the point where he was ready or apt to commit suicide?

7 A I can't comment on that.

8 Q But it is possible?

9 A I suppose it is possible, if one makes a lot
10 of other assumptions.

11 Q Is it not probably in the area of schizophrenia
12 if a person is acutely ill, if he is not treated properly
13 the suicide probability is there if he is not treated
14 properly?

15 MR. PARKER: I have got to object.

16 MR. MURRAY: It is a hypothetical.

17 THE COURT: You are saying now treated properly.
18 It was a question of admission, wasn't it? What are
19 you referring to?

20 O Don't you think, Doctor, a failure to admit is
21 not being a failure to treat properly if he should
22 have been admitted in fact?

23 A I think we are using the word treated in two
24 different ways.

25 Q Assuming he was admitted to the hospital would

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2 he not be treated? Let's assume a doctor like yourself
3 treated Mr. Cox on September 20, 1972 and determined he
4 was in need of medical treatment. I don't believe in
5 the hospital record in North Carolina they said he was
6 cured, did they?

7 THE COURT: Is that a question or statement now?
8 Are you testifying?

9 MR. MURRAY: I will withdraw etc.

10 Q The last hospital record in North Carolina,
11 did the hospital record say he was cured?

12 A No.

13 Q Didn't it indicate to you as a qualified
14 psychiatrist he needed further treatment?

15 A Yes.

16 Q Very gravely he needed treatment, isn't that
17 correct, Doctor?

18 A I can't make a judgment to that effect.

19 Q But he needed treatment?

20 A He needed treatment, yes. Further treatment.

21 Q So with that in mind, taking into consideration--
22 of course I have to use possible, I guess, because you
23 never examined him, but from your background and reading
24 and handling many cases I guess you have handled many
25 cases such as Mr. Cox?

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A I have.

Q And you researched many cases that you had not handled that other doctors have?

A My research has been in a narrower area, but I have had a broad clinical exposure to this.

Q Is it not within the realm of distinct realistic possibility that he was at a point where he might have been in the area of getting ready to commit suicide?

A The fact that there was a three-week interval attenuates that possibility considerably in my mind.

Q Let me put it this way. He is released from the hospital in North Carolina, okay?

A Yes.

Q Then he presents himself at the hospital, that is the assumption you are making, this is a hypothetical.

A Yes.

Q He presents himself to the VA Hospital in New York on September 20th and as you point out the proper medical practice was not followed in evaluating him. Then I believe some 22 or 23 days later, I believe that is approximately correct, October 12th, I believe, he commits suicide. Isn't it within the realm of realistic possibility that this man, with his history,

1 might have tended to go towards suicide?

2 A Without that information I find it difficult
3 to comment on that.

4 Q But it could have?

5 A I don't know what the realm of realistic
6 possibility is.

7 Q But with a patient of this background, he
8 may very well likely have been able to commit suicide
9 at the time he went to the VA Hospital on September 20th
10 in New York.

11 A But he didn't.

12 Q I beg your pardon?

13 A He did not commit suicide on September 20th.

14 Q But he could have been ready to do it at that
15 point.

16 THE COURT: The doctor said he didn't. You have
17 to deal with what facts you have.

18 Q Isn't it possible he might not have had the
19 implements available?

20 THE COURT: The implements for what?

21 THE WITNESS: To commit suicide.

22 A There are always such implements available.

23 Q Isn't it possible that his condition progressed
24 because of failure to treat from September 20th to October
25

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2 12th?

3 THE COURT: You say a failure to treat. A
4 failure to admit, isn't that what you are referring to?

5 Q I'm sorry, a failure to admit and therefore no
6 treatment was administered by the hospital. I stand
7 corrected.

8 A It seems to me we are dealing with a situation
9 where many causes properly operated on the patient,
10 least among which is the fact he had an illness the
11 nature we don't understand. Of all the causes I could
12 postulate, this failure to have him seen properly is
13 certainly one, but doesn't seem in my mind to be a
14 very powerful operating cause.

15 Q Let me put it another way. Suppose a doctor
16 like yourself, eminently qualified, saw Mr. Cox on
17 September 20th and he evaluated that he needed immediate
18 hospital treatment. All right? In your opinion is it not
19 unlikely that he was cured in the short interval
20 on his own without any treatment from the release from
21 Fayetteville?

22 A Schizophrenia is not a curable illness.

23 Q He had the disease. There is no question about
24 it in your mind when he appeared on September 20th.

25 A It seems reasonable to assume that.

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2 Q Within reasonable medical certainty he must have
3 had the disease on September 20th.

4 A Yes.

5 Q From your experience with these illnesses if he
6 was -- well, all right, he didn't commit suicide
7 September 20th, obviously. If he was slowly -- isn't it
8 like a progressive thing, this area of going towards
9 a suicide, acting it out?

10 A No. We are talking about the mental life of
11 a patient about which we have absolutely no information.

12 Q Doesn't the depression get worse as time goes
13 on?

14 A Not necessarily, no.

15 Q But can it not get worse or deeper?

16 A The course is very variable.

17 Q So it can get worse as time passes without
18 any medication or treatment, is that correct?

19 A Any course is possible in schizophrenia.

20 Q Let us assume he was admitted on September 20, 1972
21 and he was treated and not allowed to sign himself out
22 until he was in your opinion cured, as was the case, or
23 at least reached a certain level of being cured, being
24 able to go out into society, however you want to phrase
25 it, as he did in one or two of his earlier hospital

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2 stays. Do you not think within reasonable medical
3 certainty this suicide would not have occurred had he been
4 treated to get to that level?

5 A No.

6 Q I beg your pardon?

7 A I honestly believe that if the hypothetical
8 events you are describing had taken place, that the threat
9 of suicide would have remained because it is an inherent
10 aspect of this patient's disease.

11 Q You mean to say if he was hospitalized for a
12 year or eight months like he was, from, I believe,
13 September 30, 1968 to February 20, 1969, which was about
14 five, six months, whatever, you mean to say if he was
15 hospitalized for the long period of time like that,
16 treated, given psychotherapy, various medication or
17 whatever other treatment you deemed necessary as a
18 qualified psychiatrist, he was just as likely to commit
19 suicide when he came out as without that treatment,
20 is that what you are saying, doctor?

21 A That is not what you asked me.

22 Q All right, let me ask you that question, then.

23 A I am afraid that I would have to give you a very
24 similar answer to that, and I can cite as my authority
25 no less an authority than Eugen Bleuler, who is

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2 essentially the eminent authority on schizophrenia.

3 MR. MURRAY: Can I interrupt him?

4 THE COURT: Let him finish.

5 MR. MURRAY: I am not familiar with the Federal
6 Rules. Can he quote an authority?

7 THE COURT: Of course he can.

8 MR. MURRAY: I wasn't sure, because in the
9 State Court you can't.

10 A Blueier is a psychiatrist whose description
11 formed the basis of our practice in the United States
12 on schizophrenia. In the very end of his book Blueier
13 speculates, he points out that for all our treatment there
14 are inevitably going to be failures and I would have to
15 tell you that there is not a shred of evidence that our
16 treatments do anything more than to emeliorate the
17 course of the illness.

18 It is a very tragic situation. Therefore Bleuler
19 points out in his experience, and this is an experience
20 obviously in an in-patient setting, in fact constant ob-
21 servation and the experience of being isolated from family,
22 from social milieu, the loss of esteem that a patient
23 suffers in not being allowed to be out working and whatnot
24 may in fact make a patient more suicidal rather than less.

25 Q Let me ask you this, Doctor: I realize there

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2 are certain failures. In every field there are failures.
3 But aren't there successes?

4 A Our success rate in schizophrenia isn't terribly
5 good.

6 Q When I say success, I don't mean in curing, I
7 realize it is difficult to cure a disease of that type
8 completely, but aren't there many, many patients -- in
9 fact the majority of patients that are treated in
10 hospitals, don't they reach a level where they are able
11 to return to society and in effect do not commit suicide?

12 A Yes. But of course there are still the patients
13 who seem to resist any form of treatment.

14 Q So what I am asking you is not like a scientific
15 experiment, that water is H2O. I am asking your opinion
16 within reasonable medical certainty, what we mean by
17 that is the probabilities. In other words I am not asking
18 you to say yes, definitely Mr. Cox would have been cured
19 and he would not commit suicide. I realize you can't
20 say that. Medicine is not an exact science and neither
21 is law, but what I am asking you is using reasonable
22 medical certainty within that explanation, or within
23 that framework, is it not the case that if he was
24 admitted and given the conservative treatment, that
25 the likelihood of his committing suicide would have been

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1 very remote? Certainly shortly after his hospital
2 release.

3
4 THE COURT: You want the doctor to answer or
5 are you answering for him?

6 MR. MURRAY: No, by certainly I mean in that
7 period of time.

8 THE COURT: What is your answer, Doctor.

9 A I can't know. We are dealing with a disease
10 like cancer. It is better not to have cancer. Once
11 you have cancer all sorts of horrible things can happen
12 to you with the best treatment.

13 Q Let's talk about statistics. How many of your
14 patients commit suicide immediately after leaving the
15 hospital?

16 A I really don't have statistics on that.

17 Q You must know about some of them. If they all did
18 it you would certainly know, wouldn't you, Doctor?

19 A Well, it is uncommon for a patient to commit
20 suicide after they leave the hospital. It is uncommon
21 for schizophrenics to commit suicide. I just said it was
22 more common than in the population at large.

23 Q It is not the usual thing that when a patient
24 finishes his treatment at the VA, he walks out and gets
25 a gun and shoots himself?

1 A It is not common for a person to be turned away
2 from the admitting office and to commit suicide either.
3

4 Q But you have no way of knowing without a medical
5 evaluation what his condition was on that day, isn't
6 that true?

7 A Yes, sir.

8 Q He should have been evaluated, isn't that true?

9 A Correct.

10 Q And if it is true, it is not only malpractice
11 but gross malpractice not to examine him, isn't that
12 true, Doctor?

13 A That is a point of law which I don't know about.

14 Q From the point of view of medicine, it is gross
15 neglect not to even look at him and check him out,
16 assuming that took place?

17 A Are you saying the doctor was neglectful?

18 Q No, the institution, by not having a doctor
19 examine him because of that rule, assuming that is the
20 sequence that took place, it is gross neglect on the
21 part of the hospital, isn't that correct?

22 A I think that it is a terrible thing if it
23 happened that way. I can only speak as a layman evaluating
24 an institution. I have no medical knowledge about that.

25 Q No, you are speaking as an expert. We are
telling you as a hypothetical question that there was

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2 a supposed rule in effect that said no matter how sick
3 you are, if it is within 90 days, if you are ready to
4 jump out of a window -- the rule doesn't say that, but
5 I am just elaborating on it for the purposes of cross
6 examination; sorry, you have got to wait the 90 days.

7 If you commit suicide in the meantime it is
8 just tough luck.

9 MR. PARKER: I am going to object to that.

10 THE COURT: Sustained as to form.

11 Q There is a rule in effect. That is your hypothetical
12 assumption. Within 90 days a patient signs himself out,
13 cannot come back.

14 A Was that the rule?

15 Q That is the testimony that was given by Mrs.
16 Cox, his sister. That is what she was told.

17 THE COURT: The question was, was the rule in
18 effect then. You are simply stating what she said.

19 Q She said that she was told -- let me rephrase it.

20 She states that she was told that that was the
21 rule by the hospital admissions clerk. I didn't mean to
22 misphrase, your Honor.

23 THE COURT: You had a witness testify what the
24 rule was. You had documentary evidence in the case,
25 too. Put your questions on the basis of what is in

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2 evidence.

3 MR. MURRAY: I would like to put in evidence
4 what she said she was told, if I may.

5 THE COURT: All right, you may do that.

6 Q Mrs. Cox was told by this admissions clerk, "I
7 pulled your brother's chart," or some language along those
8 lines. "I'm sorry, but the 90 days are not up yet.
9 It is against our rules. Hospital rules are rules.
10 We cannot admit him. I can't have him examined by a doctor."

11 Don't you think that that would be a gross
12 neglect?

13 A On the part of the clerk? Absolutely.

14 Q And good medical practice would have demanded
15 and immediate physical examination, since they came to
16 the hospital for evaluation purposes?

17 A To be evaluated by a physician.

18 Q And then and only then could your testimony
19 have any meaning as to the likelihood of his committing
20 suicide or not, isn't that correct?

21 A I was asked to comment on the basis of hypotheticals.

22 Q I understand.

23 A That's what I have said all along. That I
24 can't possibly form an opinion without knowing more
25 information.

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2 Q If you had that information, then and only then
3 could you evaluate what should have been done on
4 September 20, 1972 as to whether or not he should have
5 been admitted or not?

6 A That's right.

7 Q We have no way in the world of knowing what his
8 frame of mind was at that time?

9 A I don't. Perhaps the relatives might have testified
10 to that effect.

11 Q Certainly the hospital had no way of knowing?

12 A From the record, yes.

13 Q Let me ask you another interesting question,
14 Doctor. Let me read to you --

15 THE COURT: That assumes all your questions have
16 been interesting.

17 MR. MURRAY: All right, another boring question.
18 Whatever. It is interesting to me, your Honor.

19 Q Assuming -- you are familiar with the irregular
20 discharge, are you not?

21 A Yes.

22 Q Are you aware of one of the exceptions, and I
23 quote, "Where patients --" in other words, this is a
24 patient or person who would not be allowed to apply for
25 an irregular discharge. Patients considered unable to

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adequate judgment about their best interests.

Do you recall that phraseology?

A No.

THE COURT: I don't understand what you are reading from.

MR. MURRAY: There was testimony by Mr. Pascarelli, he testified that a person could not have an irregular discharge as was given to Mr. Cox in this case if he fell into certain categories. One of them was if the patient was considered, medically, naturally, if the patient was considered unable to make adequate judgment about their best interests.

Q Let me ask you a question:

Since Mr. Pascarelli couldn't answer me because he was not a doctor, but of course you have those qualifications, how could a patient who has --

MR. PARKER: If I can just break in for a moment. I think what you are referring to is 15.10, irregular discharge.

Now-, perhaps you want to show that to Dr. Kesselman and let him look over the rule. It begins under 13.10. It runs 1, 2, 3, 4, 5 paragraphs. I think it has to be read as a whole.

MR. MURRAY: I couldn't locate it with the

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2 sheets, fine.

3 Q Would you like to read this? Rule 13.10.

4 Does that refresh your recollection about the hospital's
5 rule?

6 A Where does it come from?

7 Q The hospital. Just that one rule.

8 A Could you tell me the rule you were just reading?
9 13.10 and where?

10 Q It just continues on the other side.

11 A Where is that clause that you were talking about?

12 Q Here (indicating).

13 A I see it. Exceptions, right.

14 Yes.

15 Q Let me ask you a question. You have reviewed
16 this hospital record. What was his diagnosis, Bobby Cox?

17 A Schizophrenia.

18 Q Was it chronic schizophrenia?

19 A As I recall the diagnoses were described as.
20 acute undifferentiated schizophrenia on two occasions
21 and chronic undifferentiated schizophrenia on a third
22 occasion.23 Q Of course as we know you were not the doctor
24 making those diagnosis, so let's assume for the moment
25 it is chronic schizophrenia for the moment.

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1 MR. PARKER: Undifferentiated.

2 MR. MURRAY: Chronic.

3 THE COURT: What is your definition of the two?

4 THE WITNESS: Well, there are two components.

5 The acute really speaks to the suddenness of which symptoms
6 come on. Sometimes the word acute is used in a related
7 but different sense meaning the first such episode
8 and doctors vary in their practice as to when they use
9 that. That is one problem in the research area.

10 Undifferentiated refers to the fact that the
11 patient's symptomatology doesn't fit into one of the so-
12 called differentiated classes of illness. There is a
13 characteristic in common. Paranoid schizophrenics share
14 many features in common. Catatonics share many features
15 in common. Hyperfrenics share many features in
16 common, but by and large the great majority of patients,
17 or at least half of the patients in hospitals nowadays
18 don't have such sharply differentiated clinical pictures
19 so we tend to just simply use the term undifferentiated
20 to kind of indicate that fact.

21 Q What is the difference between acute and chronic?

22 A As I indicated it is used in two senses. Some
23 doctors will use acute schizophrenia to refer to a first
24 episode, indicating the patient had previously not
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1 shown any illness. Other doctors will use it in terms of
2 fulminance, in other words, rapidity of onset. What they
3 mean to indicate there is while the patient may have
4 shown schizophrenic symptomatology there was a kind of
5 flareup of the patient's schizophrenia so they are
6 differentiating acute from the base line state.
7

8 Q Is it not the case, Doctor, you examined the
9 North Carolina Hospital record, and I looked at the
10 last medical record that we have from the Veterans
11 Administration Hospital. 'Is it not there described as
12 a known chronic schizophrenic with a Service connection?

13 A Yes, it is.

14 Q That was the last diagnosis?

15 A Yes.

16 Q So let's assume that that was a proper diagnosis
17 and as you mentioned he was seen by a qualified psychiatrist
18 in North Carolina, is that correct, sir?

19 A That is the information I have.

20 Q Do you think a person with that diagnosis is
21 capable of making a judgment for his own adequate best
22 interests?

23 A Yes. I feel very strongly about this issue.
24 I think schizophrenia is a stigma. I think courts of
25 New York State have quite properly recognized that as an

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2 adequate guide to competency and I think if I had a
3 relative with schizophrenia, I would not want that person
4 to be tarred with that brush. I think the judgment
5 of competence is mostly a legal decision, but it is
6 a medical --

7 Q I didn't ask you about legal competency and
8 wills and contracts. I asked you a question of here
9 is a man who is chronically ill.

10 A Yes.

11 Q He wants to sign himself out of the hospital.

12 A Yes.

13 Q Is he capable of making a judgment to let
14 himself go and not get the medical treatment?

15 A I wouldn't know. I certainly wouldn't know on
16 the basis of that diagnosis. I would have to evaluate
17 that patient in relationship to his thought processes
18 at that time.

19 Q But you would be very suspect, wouldn't you?

20 A No.

21 Q If you were sent a patient, somebody walked
22 over to you now, I was diagnosed by Dr. So and so, who
23 is an eminent psychiatrist we will assume who is a chronic
24 schizophrenic, you would be very suspect not to let him
25 get treatment, would you not, Doctor?

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2 A I would want to evaluate the need for treatment.

3 Q Right. And you would think that a person with
4 that diagnosis would need extensive treatment at this
5 point?

6 A Not necessarily.

7 Q Or at least treatment?

8 A I think he should be under medical supervision.

9 Q Until he has reached a level where he is able
10 to return to society if that be the case.

11 A Well, until he is functioning in society at
12 a satisfactory level, yes.

13 Q Would not the fact that somebody was not
14 working lead you to believe he was not functioning properly
15 at that time, where he had a history of working regularly
16 before?

17 A The question would be what standard of function
18 you are talking to. Obviously I would want to know
19 a good deal more about why he wasn't working, what his
20 capacity for work was.

21 Q Wouldn't that be one factor for you to investigate
22 as a treating or examining physician, an important
23 factor to find out why he stopped working as you pointed out?

24 A It would be one factor I would want to consider,
25 yes.

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2 Q A factor like that would lead you to be suspect
3 that he needed treatment at that point, immediate
4 treatment, is that not the case?

5 A You want me to answer to immediate treatment?

6 Q Yes.

7 A I don't think it would necessarily lead to the
8 conclusion that he needed immediate treatment. In fact
9 the great majority of patients with schizophrenia --
10 you know, let me take that back because it is not what
11 I meant to say.

12 Many patients with schizophrenia don't work or are
13 required some sort of shelter environment without being
14 either suicidal or emergent in their need for treatment.

15 Q Let's review this record very briefly. Mr. Cox,
16 as you know, went to the Service and I believe it shows he
17 had no previous psychological or psychiatric problems.

18 A Right.

19 Q He comes back from Vietnam, and I don't want to
20 bore you and the Court with all the dates, you had all the
21 dates. He had innumerable hospitalizations, or a number
22 of them, let's say.

23 A Yes.

24 Q All right. Do you consider him, particularly
25 the incidents where he signed himself out without medical

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1 advice -- do you consider this good medical practice
2 to allow a patient who is in a hospital for treatment
3 after a couple of days to get up and walk out before
4 he is given the proper treatment?
5

6 A The word good bothers me.

7 Q Acceptable medical practice.

8 A I think I would have to say that it is acceptable
9 medical practice without saying that it represents
10 a desirable state of affairs, but I am limited as a
11 hospital physician in my capacity to involuntarily
12 hospitalize a patient by the laws of the state.

13 Q We are not talking about the laws of the state
14 now. We are not talking about civil rights and the laws,
15 but do you consider that the desirable way to
16 treat a patient?

17 A It may be.

18 Q To let him go after staying there for two days
19 when he is acutely ill?

20 THE COURT: First he was there overnight.

21 MR. MURRAY: Overnight would be two days,
22 I believe.

23 THE COURT: From August 20, 1972 and discharged
24 on August 21, 1972.

25 MR. MURRAY: I believe that would be two days.

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1 THE COURT: Is there anything in the record
2 to indicate that the doctor should have prevented him
3 from signing himself out?
4

5 THE WITNESS: No, there isn't.

6 Q Is there anything in the record to show
7 that diagnosis of chronic schizophrenia was adequately
8 treated in those two days?

9 MR. PARKER: I am going to object to the question.
10 The record indicates that Mr. Cox insisted on leaving
11 the hospital, he called his mother, she came down,
12 there was some consultation. According to her they
13 said the treatment was needed. She said that she was
14 going to take him to the New York Veterans Administration
15 and then he was discharged against medical advice
16 with the mother signing a slip saying that she was
17 taking responsibility for him.

18 Now, if your question is did the hospital
19 deviate from accepted medical practice in following that
20 procedure. I believe it is an appropriate one, but as the
21 question is phrased I don't think that it is relevant.

22 THE COURT: Now what is the question now that
23 you made the statement?

24 MR. MURRAY: Read the question back, please.

25 THE COURT: No, I think you lost yourself.

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You want your last question read?

MR. MURRAY: If you don't mind. It is a rather brief question.

(Record read.)

A By adequate treatment do you mean that it was treated as long and as fully as the doctors would have desired? I think the answer is clearly no and the AMA indicates that they advised him against terminating his treatment.

Q Is this a very desirable way to practice medicine, to have a young man come back from Vietnam, constantly signing -- periodically rather, signing himself in. Wouldn't it be better to have himself cured or at least reach a level inasmuch as the doctors are able to at that point, wouldn't that be more desirable?

A Yes.

Q In view of the inherent danger of, in schizophrenia as you pointed out, of suicide, would it not be incumbent upon a doctor treating Bobby Cox to take that possibility into account and ask the director to hold him for involuntary confinement?

A We had situations like this very frequently. We know pretty much what legal constraints we are operating under. We know what the standard practice is,

you know, in our areas. At least I have had much experience where this has happened, several times a month, where a patient -- that would be an extraordinary step and it would not be sustained under our understanding of the law of this state.

Q Assuming that his mother was called by the doctors in North Carolina, or New York or wherever, and she gave him the history and he threatened suicide or was asking for her gun. Do you not think from your experience, Doctor, that you would have medical grounds to satisfy the legal criteria to have him committed?

A. Well, again we are getting into the issue of imminence. If you are saying that the mother comes in with the patient and says just now -- he has been talking this way and asking for a gun and I am concerned about him, I would certainly not let that patient leave the hospital, you know, even if it required using some sort of involuntary, you know, kind of procedure, yes.

Q Would it not be accepted medical practice before a schizophrenic patient is released against medical advice, that the family would be called in to discuss the entire history to find out if there is any imminent threat of suicide?

1
2 A Are you talking about at Fayetteville?

3 Q Either one.

4 A It is good practice to contact the family, to
5 be as sure as possible about what you are saying the
6 patient should do.

7 Q If there is testimony that no doctor or no
8 member of any hospital -- you know, administrative or
9 medical -- ever asked or advised any members of the
10 Cox family that they had the option of committing him,
11 do you think that would be acceptable medical practice?

12 A You are asking me to act on two hypotheses,
13 A that he was imminently suicidal and B in that case,
14 which is hypothetical in the first place, the doctor
15 hadn't advised the family about it. If in fact he wasn't
16 imminently suicidal, then the doctor might prefer seeing
17 if he could get Mr. Cox's cooperation. Dr. Singer
18 obviously had Mr. Cox's cooperation. We don't want to
19 force our patients to stay in the hospital and then
20 lose any chance of getting their cooperation for what
21 may be a long treatment relationship.

22 Q But on the other hand if he is a chronic
23 schizophrenic with a threat of suicide you may lose him
24 in another way, isn't that a fact, Doctor?

25 A With a danger of suicide, yes, and that is a

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2 judgment that is incumbent upon us to make every time
3 we come in contact with a patient.

4 Q All your conservative treatment if you have
5 deliberate, would be forethought, if the patient
6 actually did commit suicide, isn't that a fact?

7 A I am not sure what you mean by conservative
8 possibility. I think we operate within the legal framework
9 to make sure any patient who we feel is suicidal doesn't
10 leave our care.

11 Q What is important about having a patient come
12 in and out of hospitals and not reach the optimum of
13 care, what is the point of that medical treatment, that
14 point of view?

15 A Your question implies that we are allowing it
16 to happen. We work within the legal framework of
17 what the state considers appropriate grounds for detention
18 of a patient unvoluntarily. I think most psychiatrists
19 feel that in some ways, although there is a risk
20 at every point in treating a schizophrenic, that it may
21 in fact be helpful to the patient to be treated with
22 as much respect or as much autonomy as the law will provide
23 him.

24 The hospitals in Great Britain suffered a very
25 high rate of in-patient suicides for 30 or 40 documented

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2 years. Many of those patients were schizophrenic.

3 In 1953 the hospitals in Great Britain, under
4 the impact of the milieu therapy movement opened their
5 doors and initiated far more dignity for the patient.

6 They gave him his own clothes, they allowed
7 passes, they encouraged group meetings and psychological
8 treatment. The suicide rate in the hospital plummeted
9 appreciably. It is my opinion that what prevents
10 schizophrenics from committing suicide isn't the
11 hospitalization, it is anything that supports their self-
12 esteem.

13 Mr. Cox felt himself a failure. He was
14 always questioning whether he should be a patient,
15 whether he shouldn't get back to work. whether he
16 shouldn't be on the outside and I don't see anything wrong
17 with trying to preserve a very sick patient's self-esteem
18 as long as there is no reasonable evidence that the law
19 should intervene and detain him involuntarily.

20 Q Coming back to my other point, if he was not
21 medically evaluated, you cannot in any way determine
22 if he was properly handled, is that correct?

23 A That's true.

24 Q Let me read to you a quote from a brief in
25 this case and let's see what you think about this opinion.

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2 MR. PARKER: I am going to object to that.

3 MR. MURRAY: You don't know what it is.

4 THE COURT: I don't know what the question is.
5 I can't pass upon a question until I know what it is.6 MR. MURRAY: It is a quote from a medical expert
7 and it is a similar case to this.8 THE COURT: Are you talking to the witness or
9 what?

10 MR. MURRAY: Yes.

11 THE COURT: Please raise your voice. I would
12 like to hear it too.13 Q The quote is by Mrs. Beam, defendants' superin-
14 tendent, testified that any depressed patient is
15 apt to commit suicide. Do you agree with that remark
16 or do you have any comment to make on that?17 MR. PARKER: I will renew my objection to the
18 question.

19 THE COURT: I sustain the objection.

20 Q Do you feel that any depressed patient is apt
21 to commit suicide?

22 A No, I don't.

23 Q But you do recognize that as being one
24 of the most serious dangers of that disease?

25 A The total depression covers many different conditions,

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some of which have specific treatments, some of which are the result of the inevitable disappointments of life.

Q Let's bring it to the case at bar. Do you believe any chronic schizophrenic is apt to commit suicide?

A Does the word apt mean likely?

Q Right.

A No.

Q How would you evaluate the percentage without -- in other words, as in this case, with a hypothetical where the claim is he wasn't medically evaluated at that point, if you took a chronic schizophrenic can you give us a percentage point?

A No.

Q Is there a good chance that he would commit suicide if he has that condition chronic schizophrenic and he is not medically evaluated?

A Do you want to put a number on it?

Q I am asking you to give me your best estimate if you can.

A Chronic schizophrenics are abstractions. Patients don't become less human because they have schizophrenia. I would evaluate a patient with chronic schizophrenia very much the way I would evaluate any depressed person, taking into account that he has been suffering over

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2 a long period of time, perhaps exhausted by his
3 illness, that his mental processes under stress may
4 lead to these aberrations that I described to you before.
5 A patient isn't a statistic.

6 Q I realize that one patient may vary from another,
7 but treating the problem overall, can you give us some
8 idea as to what the likelihood would be in terms of
9 percentages or unlikely, likely, very likely or whatever?

10 A Do you want me to quote from the research
11 literature?

12 Q If you have that available, sure.

13 A There are some findings in the research
14 literature on incidents of suicide in schizophrenia
15 and the basis is judged by most authorities to be a very
16 poor basis because it is very hard to define the
17 population at risk. The figure is sometimes given of
18 10 or 11 per cent. I don't believe that figure, but that
19 is the figure that I suppose a medical student might
20 be called upon to produce on an examination. It doesn't
21 help me faced with a family in distress, a patient
22 in distress and so forth.

23 Q Do you have any figures that would bring it
24 into a case like this, chronic schizophrenia, where the
25 patient was alleged to be depressed at the time?

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2 A Do I have any figures?

3 Q Yes. When you say 11 per cent you are talking
4 of overall schizophrenia.

5 A Somebody who did research in a hospital.

6 Q Can you adapt that research from your own
7 experience using this particular illness -- you read the
8 chart. You know the young man, at least you know his
9 background.

10 A Yes.

11 Q What would you say his percentage chance of
12 committing suicide without being medically evaluated would
13 be, from your experience or reading?

14 A I simply can't put a number on that.

15 Q Can you tell me if it is a good chance or a
16 likely chance or an unlikely chance?17 THE COURT: Aren't we getting in the area of
18 speculation now? The witness has indicated what the
19 situation is.

20 Do you have anything further with this witness?

21 MR. MURRAY: No, I don't, your Honor.

22 Just one other thing.

23 Q Would the fact that there was a deposition taken
24 of a hospital doctor where it was indicated that he
25 was very helpful to you in your evaluation?

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A If I were the doctor on the 20th or right now?

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Q No. I meant assuming that further fact in your hypothetical, in addition to what I gave you previously. Would that help you in your evaluation?

5

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A It wouldn't be sufficient. Schizophrenics like all of us have good reasons to be sad. It isn't the equivalent of suicide. I would be happy if he were sad because I am more concerned of a patient so withdrawn into himself and who has given up on reality so much that he has no feelings left at all.

12

MR. MURRAY: I have no questions left, your Honor.

13

THE COURT: Do you have any questions?

14

MR. PARKER: I just have one or two.

15

REDIRECT EXAMINATION

16

BY MR. PARKER:

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Q If with Mr. Cox the standard for release with medical advice as opposed to medical advice was the freedom from the possibility of suicide, would he ever have been discharged from the New York Veterans Administration Hospital beginning from 1982?

A Well, I suppose the way you are framing your question the answer has to be no. I suppose, though, that would be true for all of us. If freedom from suicidal risk were the criteria from release.

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2 Q Assume that Mr. Cox had been admitted to the
3 Veterans Administration Hospital on September 20th with
4 the same symptoms that he manifested on August 21st at
5 Fayetteville and on September 21st he has announced
6 that he wanted to leave the hospital at the VA Hospital,
7 and you are familiar with the standards and indeed in
8 New York State where you are familiar with the standards.
9 Could the medical staff have kept him in the hospital
10 against his will?

11 A Insofar as my evidence is based on the chart,
12 no.

13 MR. PARKER: No further questions.

14 THE COURT: The witness is excused.

15 (Witness excused.)

16 THE COURT: Off the record.

17 (Discussion off the record.)

18 THE COURT: We will have a mid-morning
19 recess.

20 (Recess.)

21

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1 rmmch

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2 THE COURT: Proceed, please.

3 E R N E S T K O V A C S, called as a

4 witness by the plaintiff, being first duly sworn,

5 testified as follows:

6 DIRECT EXAMINATION

7 BY MR. MURRAY:

8 Q When did you graduate medical school, Doctor?

9 A I graduated from medical school in 1966.

10 Q What school?

11 A The Upstate Medical College of the State Univer-
12 sity of New York.13 THE COURT: You will have to raise your voice,
14 Doctor. I am having difficulty hearing you.15 THE WITNESS: The Medical College of the State
16 of New York at Syracuse, sir.

17 Q Did you enter into a field of specialty?

18 A Yes, I did. I entered into psychiatry.

19 Q What training did you receive in that specialty
20 prior to practicing psychiatry?21 A I took a six-month internship in psychiatry
22 in Syracuse; I took a three-year residency training program
23 in psychiatry at the Albert Einstein College of Medicine
24 in the Bronx, New York; a one-year fellowship in social
25 psychiatry in the Albert Einstein College of Medicine in

1 rmmch Kovacs- direct 204

2 New York. And that completed my training period.

3 Q Did you also work for the Veterans Administration
4 Hospital in psychiatry subsequent to your training?

5 A No. In the course of my training, my six-month
6 internship in Syracuse, that was spent at the Veterans
7 Administration Hospital in Syracuse.

8 Q You dealt with psychiatric patients there?

9 A Yes.

10 Q You are familiar with their procedures?

11 A To some extent.

12 Q When you finished your internship, what year
13 was that?

14 A My internship was completed in 1967.

15 Q Did you enter the area of private practice?

16 A Not at that time.

17 I entered private practice at the completion
18 of my residency training program at Albert Einstein
19 College of Medicine in 1970.

20 Q How long was your internship at Albert Einstein?

21 A I should make a distinction.

22 Internship was the one-year immediately following
23 medical school, spent at Syracuse. Residency training was
24 a three-year period spend at the Albert Einstein College
25 of Medicine.

1 rmmch

Kovacs' - direct

2 THE COURT: The internship precedes the residency.

3 THE WITNESS: Yes.

4 Q Did you then enter into the private practice
5 of psychiatry?

6 A Yes.

7 Q How long have you been so doing that?

8 A Continuously since 1970.

9 Q And you have been doing this on a daily basis
10 with various patients?

11 A Yes.

12 Q Have you had any academic appointments?

13 A Yes, I have, and do.

14 Would you like me to detail them?

15 Q Yes.

16 A I was an instructor and then assistant clinical
17 professor of psychiatry at the Albert Einstein College of
18 Medicine up until 1975, and from 1975 until the present
19 I am a clinical associate professor of psychiatry at the
20 State University of New York at Stony Brook.

21 Q Have you written any publications in the field
22 of psychiatry?

23 A Yes. I provided a video-taped symposium on
24 psychiatry in the inner city, based on work done in the
25 slums of the Bronx during my training program and subsequent

1 rmmch Kovacs'- direct 206

2 positions at Albert Einstein.

3 That was published in the American Psychiatric
4 Association proceedings of 1974.

5 I conducted two panels in treatment of
6 psychotic patients in the State Hospital at the American
7 Psychiatric Association meetings in 1974 and 1975.

8 Q Doctor, to save a little time, were you
9 provided -- I show you Exhibits 1 and 2, the first being
10 the hospital record in New York of the decedent Bobby Cox
11 herein, and the second one being Exhibit 2, the hospital
12 record of the late Bobby Cox in Fayetteville, North
13 Carolina.

14 Were you provided by my office with Xerox
15 copies of the entire hospital records?

16 A Yes, I was, to the best of my knowledge.

17 Q Did you review all those records I supplied to
18 you?

19 A Yes, I did.

20 MR. MURRAY: Will the record indicate these
21 were copies supplied to me by the North Carolina counsel
22 pursuant to demand for interrogatories --

23 Can we stipulate to that, Mr. Parker?

24 MR. PARKER: Yes.

25 Q Have you read the copies of the records I

1 rmmch Kovacs' - direct 207
2 provided you with?

3 A Yes, I did.

4 Q First of all, to refresh your recollection,
5 in the summary sheet from the discharge in the North
6 Carolina Hospital, I will just read you a few lines, if I
7 may:

8 "This 28-year-old black male, known chronic
9 schizophrenic, with service connection, was admitted
10 to the closed ward on 8/20/72" --

11 And, of course, from your reading, I imagine
12 there are many other places where it is indicated -- the
13 record speaks for itself; it is in evidence -- it indicates
14 that he had a service-connected disability, namely,
15 this psychotic condition, which we will get into in short
16 order.

17 I note from your training that you worked for
18 a City hospital for some time.

19 A Yes. Part of my training program was at the
20 Bronx Municipal Hospital.

21 Q If you were on duty as admitting psychiatrist
22 and a member of decedent's family and the decedent
23 presented themselves and sought to admit him to your
24 hospital, and you found out it was a service-connected
25 disability, what would be your procedure?

